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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1997

CHARLES SHEPHARD,
Petitioner

Versus

PROVIDENT LIFE & ACCIDENTAL INSURANCE COMPANY

On Petition for Writ of Certiorari
To the United States Court of Appeals
For the Ninth Circuit
No. 95-56664

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. The fundamental question presented for review by this case is whether or not the United States Court of Appeals for the Ninth Circuit has issued a decision in direct conflict with long-standing precedent of this court by virtue of the manner in which the Ninth Circuit went about analyzing and resolving the question of whether or not an underlying District Court Decision should be enforced or vacated?
2. The case presents the corresponding question for review as to whether or not the United States Court of Appeals for the Ninth District, under the guise of determining whether or not the District Court "exceeded its authority in granting Summary Judgment to defendant, and thereby usurped the authority of the District Court?
3. This case also presents for review the question whether or not a Federal Court should, in considering the question of whether to affirm or vacate a judgment arising out of defendant's motion for

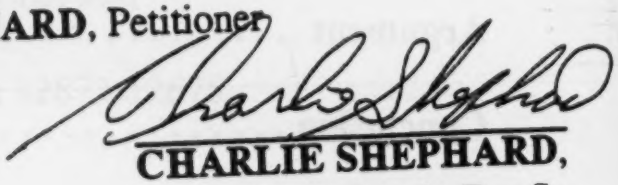
summary judgment indulge in extensive analysis of plaintiff claim of breach of contract, including the contracted provisions involved in the underlying contract, or whether the Court should in fact limit its analysis to a consideration of the question of whether the judgment "draws its essence" from the statements made by defendant's motion for summary judgment, and limit its contractual review to only defendant's statements which alleges no breach of contract or injury to plaintiff?

LIST OF ALL PARTIES

The undersigned counsel of record certifies that the following listed parties have an interest in the outcome of this case. These representations are made in order that the Judges of this Court may evaluate possible disqualification or recusal.

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, Respondent

CHARLIE SHEPHARD, Petitioner



CHARLIE SHEPHARD,
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LIST OF OPINIONS

1. Decision issued on June 19, 1996 in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit. (See Appendix 1)
2. Order denying Petition for Rehearing issued on June 10, 1997, in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit. (See Appendix 2)
3. Final Order issued by Judge George H. King on October 20, 1995, Charlie Shephard vs. Provident Life & Accident Insurance Company, Civil Action No. CV 95-0493 GHK(EX) in the United States District Court for the Southern District of California, Los Angeles Division. (See Appendix 3)

STATEMENT OF JURISDICTION

This case seeks the review of a Decision of the United States Court of Appeals for the Ninth Circuit entered on June 19, 1996. The Petitioner filed a timely petition for Rehearing, which Petition was denied on June 10, 1997. The underlying lawsuit was originally instituted in the United States District Court for the Southern District of California, under the auspices of the Contract Clause and Equal Protection Clauses of the Fourteenth Amendment. This being a case instituted under the Contract Clause and Equal Protection Clauses of the Fourteenth Amendment, seeking to recover damages for breach of contract, it is one over which the Federal Courts have jurisdiction in the first instance, and over which this Court has jurisdiction to review by Writ of Certiorari.

APPLICABLE STATUTES

1. The Equal Protection Clause of the Fourteenth Amendment of the Constitution.
2. The Due Process Clause of the Fourteenth Amendment of the Constitution.
3. The Contract Clause, Art. I, Subsection 10, Cl. 1 of the Constitution.

STATEMENT OF THE CASE

On December 23, 1994, Appellant Charlie Shephard commenced an action against Provident in the Superior Court of the State of California, in and for the County of San Bernardino, entitled Charlie Shephard v. Provident Life & Accident Insurance Company, and DOES 1 through 100, inclusive, Case No. RCV 12875, by filing a Summons and Complaint, alleging that Provident had breached its implied covenant of good faith and fair dealing with appellant, fraud, and intentional infliction of mental distress.

On January 25, 1995, Appellee filed a notice of removal of appellant's civil action from the Superior Court of the State of California to the United States District Court for the Central District of California, under 28 U.S.C. Subsection 84(c) and 1441(a).

On September 22, 1995, appellee moved for summary judgment on appellant's complaint. On October 2, 1995, appellant filed an opposition to Provident's motion for summary judgment. After purportedly considering appellee's memorandum in support of its

motion for summary judgment, and appellant's opposition to appellee's motion, the District Court on October 20, 1995 granted Provident's motion for summary judgment.

On October 30, 1995, appellant filed a timely notice of appeal, of the District Court's granting of summary judgment for Provident.

ARGUMENT

Any basic review of Federal Contract law, and of the many decisions of the Federal Courts, including this Court, on the issue, should lead one to the conclusion that there can be no question but that Provident (appellee) breached its contract, thus paving the way for plaintiff damages for its breach. The Court has no need to address the arguments concerning the alleged tortious breach of the insurance contract, a triable issue exist as to plaintiff's rights to contract damages. Hence, the summary judgment motion should have been denied. **Kouba** v. **Allstate Insurance Co.** Cite AS 523 F. Supp 148 (1981). Facts - title VII suit was brought alleging unequal pay of make and female sales agents performing equal work for Defendant Insurer. Motion for summary judgment was filed. The District Court, Karlton, J, held that: (1) employer has burden of production and burden of persuasion on affirmative defenses of Equal Pay Act; (2) Although monthly minimum for field agents merely represented a floor, it was a "wage" for purpose of Equal Pay Act. Partial summary judgment

for Plaintiff. Civil Rights 43 - Allocation of burden of proof in a title VII suit alleging unequal pay for unequal work is an issue of substantive law. Federal Civil Procedure - 2470 1 - in title VII cases, like al summary judgment motions. the court's task is the discovery of material disputes of fact, not their resolution. Federal Civil Procedure - 2470 1 - for summary Judgment Purposes a "Material Fact" is one that makes a difference in the litigation.

Conclusion – For all of the above reasons, I have determined that Plaintiff is entitled to summary Judgment on Liability. Of course, the Prop?? are left to litigate the issue of damages…

IT IS SO ORDERED.

McCormick v. Sentinel Life Ins. Co. (153 Cal. App.3d 1030; 200 Cal.Rptr. 732 [Mar. 1984] Summary Judgment § 3-Propriety. - The summary judgment procedure (Code Civ. Proc., § 437c), in as much as it denies the right of the adverse party to a trial, is drastic and should be used with caution. Summary judgment is properly granted only when the evidence in support of the moving party establishes that there is no issue of

fact to be tried. The trial court found McCormick had not identified any facts or circumstances which would constitute good cause warranting additional discovery. Since the trial court had discretion to decide this issue our review is limited to an abuse of discretion standard. We have found no such abuse and accordingly we reject this claim of error.

Disposition – The order granting the motion for summary judgment is reversed. The order denying additional discovery is affirmed. Sentinel's request for sanctions is denied and Sentinel is ordered to pay McCormick's costs on appeal. **Larraburu Brothers**, Inc., a corporation, Harold E. Paul and Harold E. Paul, Jr., Appellants, v. **Royal Indemnity Company**, a corporation, Appellee. No. 77-2229. United States Court of Appeals, Ninth Circuit. (Sept. 12, 1979)

The Ninth Circuit applies a de novo review standard to an appeal of a summary judgment. Jones v. Union Pacific R.R., 968 F.2d 937, 940 (9th Cir. 1992). In this case, the review should have been straightforward. Under Federal Rule of Civil Procedure 56(c), summary judgment is proper when there is no genuine issue as to

any material fact. Celotex Corp., 477 U.S. at 322, 106 S.Ct. at 2552, 91 L.Ed.2d at 273. Here, in this case, appellee admitted to several genuine issues as to material facts as a matter of law. Appellee admitted: (1) that it had wrongfully canceled appellant's coverage without giving notice of cancellation to appellant or the group policyholder; (2) to the denial of the payment of appellant's claims until he filed the civil action now before this Court; and (3) that its denial of coverage was erroneous, could have been disclosed by reasonable investigation. (See Appendix 4). Coverage and benefits under group health insurance plans cannot be restricted until 45 days after the insurer or plan administrator provides written notice to the group members. See Ins. C. Section 10199.1. To protect the insured's peace of mind and security, "... an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added).

The District Court's decision was erroneous in fact and law. The law states, "absent notice to the

group members individually, the insurer continues to be bound by the coverage previously provided.

The District Court viewed appellee's belated payment of appellant's claims, after being forced to file a civil action, sufficient enough to extinguish Provident's contractual obligations.

The elements of a prima facie case for the tort of intentional infliction of emotional distress are: (1) extreme and outrageous conduct by the defendant with the intention of causing, or reckless disregard of the probability of causing, emotional distress; (2) the plaintiff's suffering severe or extreme emotional distress; and (3) actual and proximate causation of the emotional distress by the defendant's outrageous conduct. Fletcher v. Western National Life Ins. Co. (1970) 10 Cal. App. 3d 376, 394 [89 Cal. Rprt. 78, 47 A.L.R.3d 286].

The three criteria for a prima facie case for the tort of intentional infliction of emotional distress were met in this case.

Appellant was subjected to prolong intentional infliction of emotional distress, dating from December

17, 1993 to present. He has watched his customer goodwill with his dental office be destroyed by such conduct by appellee. Conduct in plain language that was "clearly frivolous, clearly vexatious, or done primarily for purposes of harassment."

First, referenced records show appellee's conduct included unsubstantiated falsehood that appellant's and dependent coverage was canceled. When in fact, appellant and his dental office has been assured by appellee's representatives between March and December of 1994, prior to his filing of this civil action, that his dependent coverage was in effect, and his coverage was never canceled. Yet, during this same period, appellee submitted false statements, reneged on over 15 to 20 phone commitments, that the problem would be taken care of by Provident, and otherwise evidenced bad faith in its dealings with appellant, on each occasion, until he filed a civil action. (See Appendix 6)

Second, appellee's memorandum in support of its motion for summary judgment, show there was a failure to investigate appellant's claim that his coverage

was not canceled by appellee, until appellant had filed the civil action now before this Court. Erroneous withholding of policy benefits resulting from failure to investigate the claim thoroughly may breach the insurer's implied covenant of good faith and fair dealing with its insured. To protect the insured's peace of mind and security, "... an insured cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added).

Third, appellee's responses to requests for admissions, admit that appellant's coverage was never canceled (See Appendix 4). Coverage and benefits under group health insurance plans cannot be restricted until 45 days after the insurer or plan administrator provided written notice to the group members. See Ins. C. Section 10199.1. Provident, knew that no notice of cancellation of appellant's coverage had been sent out, based on: (1) the review of its own records which took place, prior to appellant's filing of a civil action, allowed its representatives to assess and make a deter-

mination from such records, that appellant's coverage was not canceled; (2) the 15 to 20 phone discussions appellant had with Provident's representatives; (3) the Los Angeles County Employees Retirement Association letter that was sent to appellant, which he in turn, informed Provident of the letter and its contends; and (4) its failure to notify appellant's employer of such cancellation. (See Appendix 8 and Ins. C. Section 12672-12675 at paragraph 6:885).

Appellant's medical records supports his claim that he suffers from extreme elevated blood pressure, associated with a sudden change of events in his daily life style, which he had identified as being a direct result of appellee's conduct, which is evidenced as stated above. Appellant's subjection to such conduct by appellee, has required him to start taking blood pressure medication again, medication he had been able to live without for the past 4 years.

On March 5, 1994, appellant was treated in the emergency room, for severe chest pain, headaches, and other symptoms, by Dr. Mason Weiss.

On October 29, 1994, appellant was admitted into the emergency room, treated by Dr. Nabil Noujaim, which his impressions were: (1) Cephalalgia/migraine type headache; and (2) Hypertension, medicated. Appellant's blood pressure was 142/112 on his arrival, but stabilized in the emergency room to 160/100, after receiving Reglan 10 mg IV and Phenergan 25 mg IV. Dr. Noujaim recommendation was that appellant be sent home to take blood pressure medicine on a regular basis. (See Appendix 10)

On January 5, 1995, appellant was treated by Dr. Roger Duber for uncontrolled hypertension, his impressions were: (1) Hypertension with associated hypertensive cardiovascular disease, inadequately controlled; (2) right carotid bruit; and (3) that arteriosclerotic heart disease cannot be ruled out definitively. Dr. Duber's recommendations were: (1) carotid ultrasound; (2) restart Norvasc 5 mg. Daily in conjunction with the Tenormin and Dyazide for appropriate antihypertensive therapy; and (3) Aspirin 81 mg. Daily. (See Appendix 11)

On October 3, 1995, appellant was given a physical examination by Frank J.Y. Hsu. Dr. Hsu's impres-

sion was hypertension, and put back on blood pressure medication, namely, Norvasc 5 mg. Daily, Atenolol 50 mg. Daily, and Diazide 1 mg. Daily. (See Appendix 10)

On December 6, 1995, appellant was treated by Psychologist Richard K. Smith for emotional discord and disturbance and it represents a significant psycho-social stressor. (See Appendix 10)

Appellant's present medical condition started when he was forced to prove that his dependent was a full time student, before appellee would honor his dependent claims, although, appellee was still collecting its premium, had failed to give a 45 day notice of changes in coverage, as required by law. (See Appendix 11) Whereas, the Ins. Code states, "absent notice to the group members individually, the insurer continues to be bound by the coverage previously provided."

Appellant's dependent claims were denied until appellant filed a small claim against appellee, immediately appellee declared they had received the proof and that appellant's dependent claims would be honored. (See Appendix 6)

In Nationwide Mutual, the insured brought action against disability income insurer for bad-faith denial of coverage and for breach of contract. The Court direct a verdict for insured on contract count and entered a judgment that the insurer was acting in bad-faith in refusing to pay the insured medical claim and granted petition for writ of certiorari. In both cases the verdict shows that the insurer's was acting in bad-faith for not paying insured's claims therefore putting both insured's in fear that their medical bills would not be paid therefore causing them to suffer extreme emotional distress, and mental distress. Nationwide Mutual Insurance Company v. Henry Garrad Clay. 82-536, 82-917, Cite as 525 So. 2d Pg 1339 (Ala 1987), 525 Southern Reporter, 2d Series.

In McCormick, the court of appeals held that a finding of bad faith is not negated simply because the insurer never formally denies benefits, because in many cases a lengthy delay in resolving a claim for insurance benefits has the identical consequences for the insured as an outright denial of benefits. See McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal App3d 1030, 200

Cal Rptr 732. Here, appellee simply outright denied benefits, after being repeatedly told by appellant, that his coverage was not canceled, if so, why did he not receive a notice of cancellation as required by law. Absent notice to the group members individually, the insurer continues to be bound by the coverage previously provided. Tenzer v. Super Scope Inc. Cite AS 216 Cal Rptr 130 (Cal. 1985). Fact – Board member brought action against his corporation alleging that he was entitled to payment of a Real Estate commission for finding a purchaser for corporation's property. The Superior Court, Los Angeles County, Sara Kleban Radin, J., granted corporation's motion for summary Judgment and appeal was taken. The Supreme Court, Grodin, J., held that (1) there is no finder's fee exception to the statute of frauds. (2) Board member, as Real Estate Finder, was not precluded from invoking doctrine of Estoppel to plead statute of Frauds. (3) Whether board member acted as broker was a question of fact, precluding summary Judgment. (4) Whether board member's agreement with corporation was fair and reasonable was a question of fact, Procluding Summary Judgment Reversed.

Conclusion – Resolution of this issue requires information which at this point, does not appear in the record. For this reason, we conclude that Summary Adjudication was inappropriate. The Judgment is Reversed.

Because, appellant "was compelled" to file this civil action before appellee offered to pay appellant's claims. Because, he was compelled to file this civil action, there is a causal connection between appellant's actions and appellee's conduct. Thus, there are damages as a matter of law for breach of contract. The purpose of first party coverage is to indemnify the insured for covered losses. Thus, in first party cases, the implied covenant of good faith and fair dealing obligates the insurance company not to "unreasonably" withhold benefits. If the insurer refuses to pay what is due under the contract "without proper cause," its conduct is actionable as a tort. Gruenberg v. Aetna Ins. Co. (1973) 9 C3d 566, 573, 108 CR 480, 485. "For the insurer to fulfill its obligation ... it again must give at least as much consideration to the latter's interest as it does to its own." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 8180819, 169 CR 691, 695.

Here, the insurer filed to fulfill its obligation to appellant on two separate, but equal occasions. In December 1993, appellee denied appellant's dependent claims until he was compelled to file a claim with the Small Claims Court. Yet, immediately upon appellant's filing of referenced claim with the Small Claims Court (same as in the instance case), within less than two days appellee was able to take care of its obligation. Whereas, appellant had hassled with appellee for practically four months. Although, appellee knew it was wrongfully denying appellant's dependent coverage, because there had been no notice of cancellation or change in coverage ever sent to appellant, as required by law. Yet, the hassle continued until appellant filed said claim. The same set of circumstances exist in the instance case, prolong hassle for the payment of benefits, again appellee knew there had been no notice of cancellation or change in coverage that was ever sent to appellant, as required by law. Therefore, unless appellant receives assistance from the court, appellee will continue this pattern, of collecting premiums and hassling the insured for the payment of their benefits.

Appellee could only muster, in defense of such conduct, that such continuous and prolong bad faith conduct was due to a clerical error. When appellee's memorandum in support of its motion for summary judgment, show there was a failure to investigate appellant's claim that his coverage was not canceled by appellee. Whereas, erroneous withholding of policy benefits resulting from failure to investigate the claim thoroughly may breach the insurer's implied covenant of good faith and fair dealing with its insured. To protect the insured's peace of mind and security, "... an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1975) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added). Therefore, appellee's denial of benefits without "proper cause" is a breach of contract.

In Comunale, the court stated that: "(T)he implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty." Comunale v. Traders & General Ins. Co., supra, 50 C2d

at 658, 659, 663, 328 P2d at 200, 201, 203.

In Crisci v. Security Ins. Co. (1967) 66 C2d 425, 58 CR 13, the court relied on the dictum in Comunale, above, to impose tort liability for emotional distress and financial losses resulting from wrongful refusal to settle a liability claim against the insured "within the policy limits." The implied covenant of good faith and fair dealing was thus recognized as the source of tort duties. Crisci v. Security Ins. Co., supra, 66 C3d at 429-430, 58 CR at 16-17.

Under this "well-developed judicial history," an insurer's breach of the implied covenant of good faith and fair dealing gives rise to both contract and remedies: i.e., in addition to whatever is due under the insurance policy (contract damages), the insurer may be liable for all damages proximately resulting from its breach (tort damages) ... including emotional distress, economic losses and certain attorney fees, and, if the requirements of Civ. C. Section 3294(a) are satisfied, punitive damages as well. Gruenberg v. Aetna Ins. Co. (1973) 9 C3d 566, 574, 108 CR 480, 485. An insurer is said to act in "bad faith" when it breaches its duty to deal "fairly" and

in "good faith" with its insured. Neal v. Farmers Ins. Exch. (1978) 21 C3d 910, 921, 148 CR 389, 395, fn. 5.

Here, the only question before the court, is whether the "purported clerical error" was "reasonable" as a matter of law? Appellant contends the "purported clerical error" is nothing but appellee's last line of defense for its "unreasonable acts of bad faith."

"Bad Faith" exists where an insurer denies a claim on the ground that coverage had terminated before the claim arose. If the insurer's position is both incorrect (e.g., cancellation ineffective because of inadequate notice) and "unreasonable" (e.g., no attempt to verify cancellation), a "bad faith" action may be pursued against the insurer. Coverage and benefits under group health insurance plans cannot be restricted until 45 days after the insurer or plan administrator provides written notice to the group members. See Ins. C. Section 10199.1. Absent notice to the group members individually, the insurer continues to be bound by the coverage previously provided. Fields v. Blue Shield of Calif. (1985) 163 CA3d 570, 579, 209 CR 781, 785-786. Cancellation provisions, like other pro-

visions of the insurance contract, are subject to the implied covenant of good faith and fair dealing and cannot be used to deprive the insured of the benefit of his or her bargain. Spindle v. Travelers Ins. Co. (1977) 66 CA3d 951, 9580959, 136 CR 404, 408.

Even if Provident did ultimately offer to settle appellant's claim, it was done after appellant had incurred excess damages and filed the civil action now before the court. Appellee's unreasonable conduct, before it made the offer to pay claims, was a proximate cause of recoverable damages to the insured. For example, appellee's unreasonable delay in offering to pay claims injured appellant financially, mentally, and destroyed his customer goodwill. Bodenhamer v. Sup. Ct. (St. Paul Fire & Marine) (1987) 192 CA3d 1472, 1478-1479, 238 CR 177, 180-181; Larraburu Bros., Inc. v. Royal Indem. Co. (9th Cir. 1979) 604 F2d 1208, 1215, discussed at paragraph 12:272.

"Unreasonableness" is generally equated with "lack of proper cause" for withholding benefits. However, in the case now before this Court, appellee's "negligence" constitutes the ultimate of "unreasonable-

ness" because it was negligent in investigating and evaluating the claims it denied. Erroneous withholding of policy benefits resulting from failure to investigate the claim thoroughly may breach the insurer's implied covenant of good faith and fair dealing with its insured. To protect the insured's peace of mind and security, "... an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added). The insurer's duty to investigate "thoroughly" arises out of its implied covenant of good faith and fair dealing with the insured: "For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement... it is essential that an insurer fully inquire into possible bases that might support the insured's claim." Egan v. Mutual of Omaha Ins. Co., supra, 24 C3d at 819, 169 CR at 695 (emphasis added); Hughes v. Blue Cross of No. Calif. (1989) 215 CA3d 832, 846, 263 CR 850, 857. Where a duty to investigate has arisen (below), the insurer's failure to investi-

gate properly breaches its implied covenant as a matter of law. See Egan v. Mutual of Omaha, supra, 24 C3d at 817, 169 CR at 695; and Frommoethelydo v. Fire Ins. Exchange (1986) 42 C3d 208, 220, 228 CR 160, 167.

"If an insurance company could deny a claim without thoroughly investigating it and then defend a subsequent lawsuit on grounds which it develops during discovery for trial, the company's incentive to investigate would be significantly diminished." McLaughlin v. Connecticut Gen. Life Ins. Co. (ND CA 1983) 565 F. Supp. 434, 451 (applying Calif. Law).

An insurer that refuses to pay a claim or accept a reasonable settlement offer of the claim, in violation of its duty to consider in good faith the interest of the insured in the settlement of a claim, is liable for the injury to the insured right to receive the benefit of the insurance policy. Johansen v. California State Auto. Ass'n Inter-Ins. Bureau (1975) 15 Cal. 3d 9, 14-16, 123 Cal Rptr. 288, 538 P.2d 744; Comunale v. Trader & General Ins. Co. (1958) 50 Cal 2d 654, 659, 328 P. 2d 1989; Brown v. Guarantee Ins. Co. (1957) 155 Cal App2d 679, 682, 319 P2d 69.

The insurer's duty of good faith and fair dealing is unconditional independent of the performance of the insured's contractual obligations. Gruenberg v. Aetna Ins. Co. (1973) 9 Cal 3d 566, 578, 108 Cal Rptr 480, 510 P2d 1032.

In Johansen, the Supreme Court, said that California authorities establish that an insurer who fails to accept a reasonable settlement offer to resolve a claim against the insured, that is within the policy limits, because it believes the policy has been terminated, assumes the risk that it will be held liable for all damages resulting from such refusal, including damages in excess of applicable policy limits. In addition, the court said, an insurer who denied coverage does so at its own risk, and that if the denial is found to be wrongful, it is liable for the full amount which compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligation of the contract.

In Garner, the court said that the insurer is required to concern itself with the interests and welfare of the insured as well as its own interest and welfare, and in so doing must carefully and realistically assess the claim against the insured as to the issue of liability

and as to the potential magnitude of possible damage to determine the financial risk to each party resulting from failure to settle or attempt to settle a claim. The court said that if an insurer undertakes to carry out its duty to the insured, it is a factual question whether or not the insurer has acted in good faith and made a reasonable effort on behalf of the insured to settle a claim. Garner v. American Mut. Liab. Ins. Co. (1973) 31 Cal App3d 843, 107 Cal Rptr 604.

The Supreme Court, quoting from Comunale v. Traders & General Ins. Co. (1954) 50 Cal 2d 654, 660, 328 P2d 198, said that an insurer who denies coverage does so at its own risk. Although its position may not have been entirely groundless, if the denial is found to be wrongful, the insurer is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligation of the contract. The Court concluded that, accordingly, contrary to defendant's suggestion, an insurer's "good faith," though erroneous, belief in NON-COVERAGE affords no defense to liability flowing from the insurer's refusal to accept a rea-

sonable claim. See Johansen v. California State Auto. Ass'n Inter-Ins. Bureau (1975) 15 Cal 3d 9, 16, 123 Cal Rptr 288, 538 P2d 744.

In Anderson, the insured sought to recover against insurer and other for bad-faith refusal to honor and pay a claim under homeowners policy. The Court held that a cause of action in tort against an insurer for bad-faith refusal to honor a claim of insured may be pleaded and, under appropriate facts, may be proved and damages may be afford. The Complaint alleging that insurer and other defendants acted in b ad-faith intentionally and maliciously for purpose of harassing plaintiff insured to discourage them from asserting their rightful claim under homeowners policy and prevent them from collecting amount due under the policy.

CONCLUSION

The purpose of insurance is to protect the insured. Thus, the implied covenant of good faith and fair dealing obligates an insurer to accept, on a timely basis, claims within the policy limits, in order to avoid exposing its insured to the risk of excess liability. If insurer unreasonably refuses to settle, "simple justice" demands that it absorb the losses resulting from such refusal. Gruenberg v. Aetna Ins. Co. (1979) 9 C3d 566, 573, 108 CR 480, 485. Even if the insurer ultimately settles the claim, so that there is no excess liability, the insurer's unreasonable conduct before settlement can still be a proximate cause of recoverable damages to the insured. For example, the insurer's unreasonable delay in settling claim may injure the insured financially and destroy customer goodwill. See Bodenhamer v. Sup. Ct. (St. Paul Fire & Marine) (1987) 192 CA3d 1472, 1478-1479, 238 CR 177, 180-181; Larraburu Bros., Inc. v. Royal Indem. Co. (9th Cir. 1979) 604 F2d 1208, 1215, discussed at paragraph 12:572. Because, appellant "was compelled" to file

this civil action before appellee offered to pay appellant's claims, because appellee's denial of benefits was without good cause, constitutes an act of bad faith.

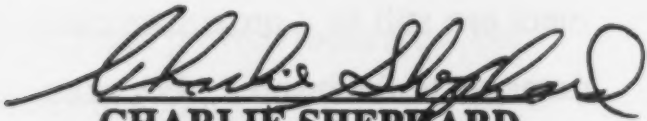
For all of the foregoing reasons, Appellant prays:

(a) For this Court to reverse the lower Court's Judgments and Orders on all issues presented on appeal, remand the case back to the District Court for trial;

(b) For all causes of action, such other relief as the Court deems proper.

Dated: December___, 1997.

Respectfully submitted,



CHARLIE SHEPHARD,
Appellant in Pro Se

LIST OF APPENDIX

1. Decision issued on June 19, 1996 in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit.
2. Order denying Petition for Rehearing issued on June 10, 1997, in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit.
3. Final Order issued by Judge George H. King on October 20, 1995, Charlie Shephard vs. Provident Life & Accident Insurance Co., Civil Action No. CV 95-0493 GHK (EX) in the United States District Court for the Southern District of California, Los Angeles Division.
4. Defendant's Admissions that it had wrongfully canceled appellant's coverage without giving notice of cancellation to appellant or the group policyholder.
5. Letter from plaintiff's dental office stating his dependent was covered under his policy and inforce.

6. Plaintiff's filing of small claim to get defendant to honor policy and the start of its continuous acts of bad faith.
7. Letter from policyholder stating plaintiff's coverage has never been canceled and copies of premium payments deducted from plaintiff's pay.
8. Appellant's proof of additional emergency room treatment as a result of defendant's continuous acts of bad faith.
9. Appellant's proof of medical treatment for uncontrolled hypertension as a result of defendant's continuous acts of bad faith.
10. Appellant's additional proof of continuos uncontrolled hypertension as a result of defendant's continuous acts of bad faith.
10. Appellant's proof that his dependent was a full time student.

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 95-56664
D.C. NO. CV-95-004393-GHK(EX)

CHARLIE SHEPHARD,
Plaintiff-Appellant

VERSUS

PROVIDENT LIFE & ACCIDENT INSURANCE CO., MEMORANDUM*
Defendant-Appellee

Appeal from the United States District Court
For the Central District of California
George H. King, Magistrate Judge, Presiding

Submitted June 11, 1996**

Before: CANBY, NOONAN, and LEAVY,
Circuit Judges

Charlie Shephard appeals pro se the district court's summary judgment in favor of Provident Life & Accident Insurance Company in Shephard's diversi-

ty action alleging breach of contract, breach of the implied covenant of good faith and fair dealing, and fraud arising out of Provident's delay in paying two dental claims. We have jurisdiction pursuant to 28 U.S.C. S 1291. We review de novo, Barnett v. Centori, 31 F.3d 813, 815 (9th Cir. 1995), and we affirm for the reasons stated by the district court.

AFFIRM.

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

** The panel unanimously finds this case suitable for decision without oral argument. FED. R. App. P. 34(a); 9th Cir. R. 34-4.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 95-56664
D.C. NO. CV-95-00493-GHK

CHARLIE SHEPHARD,
Plaintiff-Appellant,

VERSUS

CENTRAL CALIFORNIA (LOS ANGELES) PROVIDENT LIFE & ACCIDENT INSURANCE CO.,
Defendant-Appellee.

ORDER

Before: CANBY, NOONAN, and LEAVY, Circuit Judges.

The panel has voted to deny appellant's petition for rehearing, and the panel recommends rejecting the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

NO. CV 95-0493-GHK(EX)
MEMORANDUM AND ORDER

CHARLIE SHEPHARD
Plaintiff,

VERSUS

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, ET AL.,
Defendants

This matter is before this court on defendant Provident Life & Accident Insurance Company's ("Provident") motion for summary judgment. For the reasons stated below, defendant's motion is granted.

Plaintiff brings this action in pro per to challenge defendant's delay in paying two claims for dental treatment performed in August 1994, until December 1994, upon the filing of the underlying complaint. Under plaintiff's policy with defendant, defendant was obligated to pay 80% of the cost for certain dental and vision

care services received by plaintiff. Plaintiff alleges that defendant's delay in paying these claims resulted in breach of contract, breach of the implied covenant of good faith and fair dealing, and fraud.[1]

Defendant, on the other hand, contends that its delay in paying the claims resulted from a clerical error wherein plaintiff's coverage was accidentally administratively terminated even though defendant continued to collect premium payment from plaintiff. Accordingly, defendant argues that plaintiff should not be able to maintain any of the alleged claims.

Plaintiff first alleges that defendant's refusal to pay plaintiff's claims resulted in breaches of contract. However, defendant extinguished its contractual obligations

[1]In his opposition papers, plaintiff argues that he has stated a cause of action for intentional infliction of emotional distress. However, a liberal reading of the complaint does not reveal a separate cause of action on this basis, but instead only a request for relief for emotional distress in connection with the other alleged claims. In any event, plaintiff has not proffered sufficient evidence to support a cause of action for intentional infliction of emotional distress. See Cervantes v. J.C. Penney Co., 24 Cal. 3d 579, 593 (1979).

upon payment of the claims in December 1994. See Croskey, Kaufman, et al., Cal. Prac. Guide: Insurance Litigation, 12:13 to 12:16 (The Rutter Group 1995); Reid v. State Farm Mutual Auto. Ins. Co., 173 Cal. App. 3d 557, 576, 218 Cal. Rptr. 913, 923 (1985); Cf. Paulson v. State Farm Mut. Auto. Ins. Co., 867 F. Supp. 911, 917-918 (C.D. Cal. 1994). Accordingly, defendant's motion on the breach of contract claims is **GRANTED**.

Plaintiff next asserts that defendant engaged in conduct, including delaying payment of plaintiff's benefits, that breached its implied covenant with plaintiff to deal fairly and in good faith. Defendant contends that it is not liable to plaintiff for delaying payment of benefits because it has tendered evidence that its conduct was the result of a clerical error and therefore was "reasonable" as a matter of law. Although usually a question of fact, where only one conclusion about the conduct's reasonableness is possible, reasonableness becomes a question of law appropriate for summary judgment. West v. State Farm, 868 F. 2d 348, 350 (9th Cir. 1989). In light of the uncontroverted evidence that the four-month delay was a clerical error, plaintiff has

not made a showing sufficient to go to the jury on the reasonableness of defendant's conduct. See Neal v. Farmers Ins. Exch., 21 Cal. 3d 910, 925, 148 Cal. Rptr. 389, 397 (1978). Thus, defendant's motion on the breach of the implied covenant of good faith and fair dealing claims is GRANTED.

Finally, plaintiff alleges that defendant's conduct with regard to the payment of plaintiff's claims amounted to fraud. However, plaintiff has not tendered sufficient evidence to go to the jury on each of the required elements of fraud. See Handel v. United States Fidelity and Guar. Co., 192 Cal.App. 3d 684, 693, 237 Cal. Rptr. 667, 671-72 (1987); Miller v. National Am. Life Ins. Co. of Cal., 54 Cal. App. 3d 331, 337-41, 126 Cal. Rptr. 731, 734-36 (1976). As a consequence, defendant's motion on the fraud claims is GRANTED.

IT IS SO ORDERED.

Dated: This ___ day of October, 1995

GEORGE H. KING
United States District Judge

GALTON & HELM
STEPHEN H. GALTON (State Bar No. 46732)
CHRIS D. OLSEN (State Bar No. 151007)
500 South Grand Avenue, Suite 1200
Los Angeles, CA 90071-2609 (213) 629-8800

Attorneys for Defendant
PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV-95-0493
DT (EX)
RESPONSES TO REQUESTS FOR ADMISSIONS

CHARLIE SHEPHARD,
Plaintiff,

VERSUS

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, and DOES 1 through 100, inclusive,
Defendant.

PROPOUNDING PARTY:
Plaintiff CHARLES SHEPHARD
RESPONDING PARTY:
Defendant PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY

SET NUMBER: One

At the time of answering Request for Admissions, Defendant PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY ("PROVIDENT") has not completed its discovery or investigation with respect to the facts and issues of this case. PROVIDENT therefore serves its Responses to Request for Admissions based upon available information without prejudice to PROVIDENT's right to introduce evidence at trial which may be discovered through future investigation and discovery, and to assert new or additional issues based upon such subsequently discovered evidence. Moreover, in answering Request for Admissions, PROVIDENT does not intend to waive any privileged attorney-client communications and/or attorney work-product relative to the subject matter of Request for Admissions.

REQUEST FOR ADMISSION NO. 1:

Admit that Plaintiff's coverage for Daughter, Angela, has no bearing on this case.

RESPONSE TO REQUEST FOR ADMISSION NO. 1.:

Objection. PROVIDENT objects to this request on the grounds that it is vague, ambiguous, and unintelligible with respect to the use of the words "no bearing on this case." Plaintiff's Complaint contains references to facts relating to insurance coverage for Plaintiff's daughter, Angela. PROVIDENT would be willing to stipulate, however, that Plaintiff is not seeking any damages in this case relating to insurance coverage for Plaintiff's daughter, Angela.

REQUEST FOR ADMISSION NO. 2.:

Admit that Plaintiff had full coverage on August 10, 1994, and continuing thereafter pursuant to a plan with Los Angeles County Employees Retirement.

RESPONSE TO REQUEST FOR ADMISSION NO. 2.:

Admit that Plaintiff was covered under PROVIDENT Group Policy No. 11042, issued to the Los Angeles County Employees Retirement Association, for dental and vision benefits, on August 10, 1994, and at all times thereafter, to date.

REQUEST FOR ADMISSION NO. 3.:

Admit that Plaintiff's coverage was never canceled

RESPONSE TO REQUEST FOR ADMISSION NO. 3.:

Admit that Plaintiff's coverage under PROVIDENT Group Policy No. 11042 was never canceled as to himself, however Plaintiff did cancel coverage under the same policy for his daughter, Angela.

REQUEST FOR ADMISSION NO. 4.:

Admit that Provident failed and refused to make payment on claim(s) submitted on August 10, 1994 and August 16, 1994.

RESPONSE TO REQUEST FOR ADMISSION NO. 4.:

Objection. PROVIDENT objects to this request on the grounds that it is vague and ambiguous as to time. Although PROVIDENT originally denied Plaintiff's claims for dental treatment obtained on August 10, 1994 and August 16, 1994, PROVIDENT has since made payments on these claims.

DATED: June 6, 1995

GALTON & HELM
CHRIS D. OLSEN

BY_____
CHRIS D. OLSEN
ATTORNEYS FOR DEFENDANT
PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY

MISSION DENTAL CARE
KYUNG H. CHUNG D.D.S.
941 W. Mission Blvd., Suite H., Ontario, California 91761
OFFICE TELEPHONE
(714) 984-7883

MARCH 1, 1994

CHARLIE SHEPHARD
C/O: ANGELA SHEPHARD
P. O. BOX 521
ONTARIO, CA 91761

DEAR MR. SHEPHARD,

ON 12-17-93 A CALL WAS MADE TO YOUR INSURANCE COMPANY TO VERIFY ELIGIBILITY AND BENEFITS FOR YOUR DEPENDENT ANGELA PRIOR TO HER SCHEDULED APPOINTMENT ON 12-22-93. PER MRS. DANIELS AT THE INSURANCE COMPANY WE WERE GIVEN THE INFORMATION THAT ANGELA WAS COVERED AS YOUR DEPENDENT AND BENEFITS WERE THE SAME AS YOURS WHICH WE ALREADY HAVE ON FILE.

WE AT MISSION DENTAL CARE ALWAYS VERIFY THIS INFORMATION TO AVOID THIS PROBLEM FROM HAPPENING PRIOR TO THE PATIENT BEING SEEN. WE LIFE TO UPDATE ANY CHANGES FROM THE INSURANCE AS FAR AS BENEFITS, ELIGIBILITY, OR EVEN A CHANGE IN THE INSURANCE COMPANY TO INFORM THE PATIENTS BEFORE ANY TREATMENT IS STARTED EVERY 6 MONTHS IF PATIENT IS SCHEDULED FOR AN APPOINTMENT.

I HOPE THIS LETTER WILL BE HELPFUL IN RESOLVING THE PROBLEM WITH THE INSURANCE COMPANY. IF ADDITION INFORMATION IS NEEDED FROM OUR OFFICE PLEASE GIVE ME A CALL.

SINCERELY,

NORMA RAMIREZ
Office Manager

PROVIDENT LIFE & ACCIDENT
INSURANCE COMPANY
FOUNTAIN SQUARE
CHATTANOOGA, TN 37402
(615) 755-2433

APRIL 7, 1994

VIA CERTIFIED MAIL

MR. CHARLES SHEPHARD
Post Office Box 521
Ontario, California 91761

Re: Charles Shephard v. Provident Life and Accident Insurance Company

Dear Mr. Shephard:

Provident has reviewed the dental claim for services your daughter Angela received in December 1993 at Mission Dental Care and it concluded that the claim should have been covered because Angela was an eligible dependent at the time those expenses were incurred. The benefits payable are $128.00. Since the bill for those services have been paid in full according

to Carmen at Mission Dental Care, the check for that amount will be sent to you.

Provident also reviewed your March 1994 letter to Ronald LaFourcade and the information in Provident's claim system. It appears the claim office did not have the information confirming Angela's eligibility and it denied the claim when it was first processed. After it received that information, the claim office overlooked the claim.

Although most, if not all, of the expenses you listed in your March 24 letter to Mr. La Fourcade are not recoverable under the LACERA policy, because of the inconvenience Provident's handling of the claim may have caused you, Provident is offering to pay an additional $500.00 over and above the $128.00 in benefits in exchange for your dismissing the Small Claims Court action you filed. By agreeing to settle and dismiss the action, both you and Provident can avoid the inconvenience and uncertainty of the hearing scheduled for April 20.

I will be happy to discuss this further with you. Please contact me before April 13.

Very truly yours,

JAMES O. UMEDA
Counsel

JOU:jjh
T\jou\u0407j01

LACERA

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. Lake Ave., Pasadena, CA 91101 - Mail to: PO Box 7060, Pasadena, CA 91109-7060 818/564-6132 - 800/786-6464

MAY 9, 1995

CHARLIE SHEPHARD
P.O.Box 521
Ontario, CA 91762

Dear Mr. Shephard SSN: 251-54-2754

We received your correspondence on May 8, 1995 requesting an explanation as to why your Provident Dental/Vision coverage was canceled. However, after researching our records, we found that your Dental/Vision coverage has never been canceled.

Our records indicate the only actions taken on your account regarding insurance was where we deleted your daughter from your coverage, as per your request.

An acknowledgment letter was sent to you notifying you of this transaction.

If you should have any questions, please contact LACERA Insurance Services Section at the numbers provided above.

Very truly yours,

CASSANDRA SMITH
Insurance Services Section

CHARLIE SHEPHARD
P.O. BOX 521
ONTARIO, CALIFORNIA 91762
Plaintiff In Pro Per

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CASE NO. CV-95-0493
DT (EX)
AFFIDAVIT OF NABIL NOUJAIM, M.D.

CHARLIE SHEPHARD
- Plaintiff

VERSUS

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, AND DOES 1 THROUGH 100, INCLUSIVE
- Defendant

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES

I, Nabil Noujaim, M.D., being first duly sworn, depose and say:

1. I am a physician duly qualified to practice in the State of California.

2. I examined patient, Charlie Shephard on October 29, 1994 in the emergency room of Valley Medical Center.

3. Attached hereto as EXHIBIT "A" a true and correct copy of the medical report for patient, Charlie Shephard.

I declare under penalty of perjury that the foregoing is true and correct.

In Witness Whereof, I have hereunto set my hand this _____ day of _____,19_____.

NABIL NOUJAIM, M.D.

Subscribed and sworn to before me this 4 day of August, 1995.

ROBERTA A. HEYES, NOTARY PUBLIC
Notary Public in and for said County and State

CHINO VALLEY MEDICAL CENTER
5451 Walnut Avenue, Chino, CA 91710 (909) 464-4600

DATE OF VISIT: 10/29/94
TIME OF VISIT:
HISTORY:

This is a 59-year-old male who comes into the emergency room with chief complaint of lift sided headache. The patient states the last two weeks off and on he has had this ache that has been getting excruciatingly worse, especially last night, over the left lateral aspect of his head. He states that at times he has blurry vision but denies having any trauma. Denies having any fever or chills. Denies having any vomiting but has been having some nausea, as well. He states that his scalp is tender. In addition to all of this, he also has been under a lot of stress, he states, over a number of issues including the insurance company that is not paying his bills and states that he started having to use high blood pressure medication to regulate his blood pressure because previous to that he was not medicated. The patient states that he has been

eating a healthy diet and trying to take care of himself, but has been under a lot of stress due to that situation. He does have a previous history of hypertension. He is currently on Procardia over the last two weeks.

PHYSICAL EXAMINATION:

He is alert and oriented times four. Neurologically, he is non-focal. HEENT: Atraumatic, normocephalic. Ear, nose and throat are clear. Cranial nerves II-III are intact. The temporal areas are non-tender. No evidence of temporal arthritis. NECK: Supple. No menigismus. HEART: Regular rate and rhythm. LUNGS: Clear. ABDOMEN: Benign. EXTREMITIES: Normal. NEURO: Non-focal.

EMERGENCY DEPARTMENT COURSE:

The patient's blood pressure was 142/112 on arrival, but stabilized in the emergency room to 160/100 and has been doing quite well in the emergency room. The blood pressure and vital signs have been stable and

neurologically, he has been intact. The patient received Reglan 10 mg IV and Phenergan 25 mg IV following which he started feeling much improved as far as his headache was concerned. CT scan was done without contrast. This was read by the radiologist as showing some diffuse atrophy with no evidence of acute process. No bleeding. ABG is normal. Electrolytes are normal. Chloride is slightly elevated to 114. Amylase is 58. H&H is 14 and 41. EKG shows a normal sinus rhythm. The patient has been stable in the emergency room under observation. He has had no ill effects. He is feeling quite comfortable at this point.

IMPRESSION:

1. Cephalalgia/migraine type headache.
2. Hypertension, medicated.

RECOMMENDATION:

The patient will be sent home to take meds on a regular basis. He needs to be on a low salt diet, to rest, to

see his physician in 48 hours, and return to the emergency room if there is any difficulty.

NABIL NOUJAIM, M.D.

NN/BS
S: 10/29/94
T: 11/L/94
JOB#: 9854
PAGE 2

EMERGENCY REPORT

SHEPHARD, CHARLIE
MR. #: 807557
NABIL NOUJAIM, M.D.

CHINO VALLEY MEDICAL CENTER
5451 Walnut Avenue, Chino CA 91710 (909) 627-6111

DATE: 8-2-95

VERIFICATION OF HOSPITAL STAY

REGARDING PATIENT: Charlie Shephard
DATE OF BIRTH: 9-21-35

This is to verify that the above referenced patient was hospitalized at Chino Valley Medical Canter on the following dates: 10-29-94 Under the care of the following attending physician: Dr. Noujaim
Any further information may be obtained only on written consent of the patient.

WAULEAH LARSON, ART
Custodian of Records

ROGER D. DUBR, D.O. FAGC
CARDIOLOGY - BOARD CERTIFIED
685 N. 13th Avenue, Upland, California 91786
(909) 981-8383

JANUARY 5, 1995
ANGELYN MOULTRIE, D.O.
360 EAST MISSION BLVD.
POMONA, CALIFORNIA 91766

RE: SHEPHARD, CHARLIE
Cardiology Consultation

Dear Angie:

I had the pleasure of evaluating your patient, Mr. Charlie Shephard, in my office on January 5, 1995, in regards of evaluation for uncontrolled hypertension.

HISTORY OF PRESENT ILLNESS: As you recall, Mr. Shephard is a pleasant 59-year-old Afro-American male who was first noted to have hypertension ten years ago. He was at first able to be treated without medication, but for the past year has been requiring

aggressive medical therapy and still had very difficult blood pressure to control. Because of that he sent here for further evaluation as well as having an abnormal EKG.

He has no history of myocardial infarction and he denies any history of rest or exertional chest pain.

He denies any significant exertional dyspnea, orthopnea, ankle edema or paroxysmal nocturnal dyspnea.

He has no known history of heart murmur or rheumatic fever.

He denies any palpitations, lightheadedness or syncope.

PAST MEDICAL HISTORY: Past medical history is negative for diabetes, but positive for hypercholesterolemia.

PREVIOUS SURGERIES: Negative.

HABITS: Denies ethanol, drug, tobacco or caffeine abuse.

REVIEW OF SYSTEMS: Essentially noncontributory.

PRESENT MEDICATIONS: Present medications include Dyazide 1 capsule daily, Norvasc 5 mg. Bid up until yesterday and then as of this morning he as switched to Tenormin 50 mg. Daily.

PHYSICAL EXAMINATION: Physical examination reveals a pleasant 59-year-old Afro-American male, in no apparent distress, with no gross deformities, or mesomorphic stature, appearing appropriate for his stated chronological age.

VITAL SIGNS:

WEIGHT: 204 lbs.

BLOOD PRESSURE: 160/100, right arm supine position. 150/95, right arm upright position. 130/100, left arm upright position.

APICAL RATE: 72 and regular.

NECK: There is no neck vein distention nor hepato-jugular reflux. The thyroid gland is non palpable. No lymphadenopathy is noted.

CHEST: The chest reveals bilateral symmetry.

LUNGS: The lungs are clear to auscultation and percussion.

HEART: Examination of the heart reveals the PMI to be in the 5th ICS, MCL, no precordial.heave is noted. Auscultation reveals the rhythm to be regular with normal first and second heart sounds. No S3, S4, murmurs, rubs or clicks were noted.

ABDOMEN: The abdomen is soft without masses, tenderness or organomegaly.

EXTREMITIES: The extremities reveal no peripheral edema. The peripheral pulses are intact with a right carotid bruit noted. No other bruits or abnormalities were noted.

ELECTROCARDIOGRAM: The electrocardiogram reveals normal sinus rhythm with left ventricular hypertrophy and secondary repolarization abnormalities.

IMPRESSIONS

1. Hypertension with associated hypertensive cardiovascular disease, inadequately controlled.
2. Rule out left ventricular diastolic dysfunction secondary to number one.
3. Right carotid bruit. Rule out arteriosclerosis obliterans asymptomatic.
4. Arteriosclerotic heart disease cannot be ruled out definitively.

RECOMMENDATIONS:

1. Carotid ultrasound.
2. Restart Norvasc 5 mg. daily in conjunction with the Tenormin and Dyazide for appropriate antihypertensive therapy.
3. Aspirin 81 mg. daily.
4. An echocardiogram will be performed to rule out left ventricular diastolic dysfunction secondary to left ventricular hypertrophy.
5. With your permission I will re-evaluate the patient in approximately two weeks.

Thank you again for allowing me to participate in the

care of your patient. If you have any further questions, please do not hesitate to contact me.

SINCERELY,

ROGER D. DUBER, D.O.
RDD:cjs

FRANK J.Y. HSU, M.D., FCCP
Diplomate of American Board of Internal Medicine
Diplomate of American Board of Pulmonary Medicine
Diplomate of American Board of Critical Care Medicine

October 3, 1995

HISTORY AND PHYSICAL
Re: Charlie Shephard

Chief Complaint: Headache and anxiety.

Present Illness: This is a 56 year old male patient who is known to have hypertension for years. He was under physicians care, taking multiple blood pressure medications. In November, 1994 he started a law suit against insurance company for unpaid medical care. He takes care of case himself without attorney and has been under great deal of stress especially in recent days after having long deposition taken. He stopped taking the blood pressure medication a week ago for reasons unspecified. He has complained of headache and he could not sleep all night because he has to study the law himself.

Past Medical History: Otherwise unremarkable. He denied any history of cardiac disease or diabetes. He denied any drug allergy.

Social History: Does not smoke or drink.

Family History: Not contributory to present problem.

Physical Examination:

General: Physical examination revealed a middle aged Black male individual in his fifties. He is awake, alert and oriented. In no distress.

Vitals: Blood Pressure: 200/100
Heart Rate: 80 per minute, regular

Skin: His skin turgor is normal. No signs of dehydration and no abnormal rash.

HEENT: Head is atraumatic. Eyes revealed no palor or jaundice. Pupils are reactive to light. Eye ground is

clear. Ears, nose and throat is unremarkable.

Neck: Neck is supple. Neck veins are not engorged. Trachea is in midline. No thyroid megaly and no carotid bruit was heard.

Chest: Chest examination revealed symmetric and unrestricted movement. Breath sounds are loud and clear throughout. There is no wheezing or rales.

Cardiac: Cardiac examination revealed regular rhythm. There is no gallop or friction rub and no abnormal murmur.

Abdomen: The abdomen is soft and non distended. Liver and spleen are not enlarged. Bowel sounds normal. There are not signs of ascites.

Extremities: Extremities show no pitting edema and no calf tenderness. Nail beds are non cyanotic.

Neurology: Neurological examination is unremarkable.

EKG: The EKG shows regular sinus rhythm. No acute ST segment changes. No arrhythmia.

Radiology: Chest x-ray is clear.

IMPRESSION: 1. Hypertension.

PLAN:

1. Chem 20 and CBC.
2. Put back on blood pressure medication namely,

   Norvasc 5mg daily, Atenolol 50 mg daily, Diazide 1mg daily.
3. Put on Xanax .5mg 2 every 12 hours prn.
4. Recheck in 2 weeks.

FRANK J.Y.HSU, M.D.,F.C.C.P.
FH:cr

9655 Monte Vista, #402, Montclair, CA 91763, (909) 626-1205
ALTA LOMA PSYCHOLOGICAL ASSOCIATES

December 19, 1995

RE: CHARLIE SHEPHARD

To Whom It May Concern:

This will confirm that Mr.Shephard has been seen on December 6, 13, 20, and December 27, 1995 in conjunction with complaints associated with anxiety, the onset of which correspond to a series of apparent misunderstandings between himself and his dental insurance company.

Per interview, symptoms include disorganized and unfocused attention, disturbed sleep patterns with multiple awakenings, forgetfulness, unsteady fine motor coordination and a subsequent deterioration of performance in some home and community skills. Home maintenance, check writing, driving, general orientation are among the areas effected. Mr. Shephard finds it difficult to initiate the day to day affairs of the

household, he has gotten his days mixed-up, (i.e. he has gone to church on the wrong day), he has paid for gas but forgotten to put it in his tank before leaving the station, he has lost his enthusiasm for cooking and describes disorganized finances. There is also a complaint of chronic and stress related headaches.

Mr. Shepherd also describes an elevated blood pressure, polyuria and episodic feelings of sadness and hopelessness. He denies alcohol or drug use and there is no suicidal ideation at this time. He has sought medical treatment through Frank Hsu, M.D. for "stress and worry" and has been prescribed a blood pressure medication as well as Alprazolam, an anti-anxiety agent known also as Xanax. Follow-up with Dr. Hsu is set for January 1996.

Mr. Shepherd is clear in his attribution of his symptoms of anxiety and his depression and his anger and frustration to a sense of betrayal and abandonment and to misrepresentation and dishonesty on the part of his insurance carrier.

For Mr. Shepherd, the level of emotional discord and disturbance is mild to moderate and it represents a significant psycho-social stressor, the dynamics of which are being monitored. Provisional Axis I diagnosis is Adjustment Disorder with Mixed Anxious and Depressed Mood.

A comprehensive summary can be generated by late January if treatment continues and if the need arises.

RESPECTFULLY,

RICHARD K. SMITH, PH.D.
Clinical Psychologist
License No. PSY 13809

9033 Baseline Road, Suite "I", Rancho Cucamonga, California
91730-1255 • (909) 980-3567

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

PROVIDENT CLAIM OFFICE
P. O. BOX 182524
CHATTANOOGA, TN 37422-7524

OPERATION LOCATION NUMBER:
09371 1 9001902

RE: CHARLIE SHEPHARD

CHARLIE SHEPHARD
P. O. BOX 521
ONTARIO, CA 91762-8521216

CLAIM TYPE: DENTAL

REFERENCE NUMBER: 0249400325854

ID NUMBER: 251-54-2754

DATE PROCESSED: 03/28/94

SERVICE DATE: 022494-022494

PATIENT-NAME: ANGELA SHEPHARD

RELATIONSHIP: CHILD

PLAN NAME: LOS ANGELES COUNTY EMPS RETIREMENT

THIS IS THE SECOND REQUEST FOR THE FOLLOWING INFORMATION.
IF YOU HAVE ALREADY RESPONDED, PLEASE DISREGARD THIS LETTER.

IN ORDER TO DETERMINE ELIGIBILITY UNDER THE GROUP INSURANCE PLAN NAMED ABOVE. WE MUST HAVE INFORMATION FROM YOUR CHILD'S SCHOOL. PLEASE HAVE YOUR CHILD SIGN THIS FORM IN THE SPACE INDICATED BELOW AND TAKE IT TO THE SCHOOL'S RECORD OFFICE FOR COMPLETION. (PLEASE NOTE, IF YOUR CHILD IS UNDER THE AGE OF EIGHTEEN, WE WILL NEED THE PARENT OR GUARDIAN'S SIGNATURE AS WELL.)

SINCERELY,
PROVIDENT
GROUP CLAIM SERVICE

I HEREBY AUTHORIZE THE RELEASE TO AND USE BY PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, ANY STUDENT INFORMATION NEEDED TO PROCESS BY CLAIM(S).

STUDENT ID#086463

STUDENT OR SOCIAL SECURITY NUMBER

ANGELA SHEPHARD

SIGNATURE OF STUDENT

4/25/94

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

THIS SECTION TO BE COMPLETED BY AN AUTHORIZED SCHOOL REPRESENTATIVE.

DEAR DEAN OF RECORDS:

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION FOR THE ABOVE IDENTIFIED STUDENT. FOR FUTURE REFERENCE, PLEASE MAINTAIN A COPY OF THIS AUTHORIZATION IN YOUR FILE.

HOW MANY UNITS QUALIFY A STUDENT AS FULL-TIME? 12.0

OR WAS THE ABOVE STUDENT A FULL-TIME STUDENT? YES

YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

SEMESTER/YEAR: FALL 1993/SPR. 1994

INCLUSIVE DATES: 08/23/93-05/13/94

UNITS ENROLLED: 14.0

UNITS COMPLETED: 46.0

IS THE STUDENT ENROLLED FOR THE NEXT TERM? NO

MT1-PRW
L#100-000 022494 004113 E

FISCAL YEAR 93 - 94
HOWARD UNIVERSITY PAGE 01 OF
OFFICE OF THE BURSAR
STATEMENT OF ACCOUNT FOR PERIOD ENDING 9/02/93

ID NUMBER: 086463
STUDENT NAME: SHEPHARD, ANGELA
SCHOOL: SN
CLASS: 2

BALANCE AT BEGINNING DATE 063093 - 826.00CR

DATE	TRANS/DESCRIPTION	AMOUNT	SEM/YR
07/02/93	ROOM RENT		SU 93
08/24/93	TUITION		FA 93
08/24/93	ENDOWMENT FEE		FA 93
08/24/93	SELF HELP FEE		FA 93
08/24/93	MATRICULATION FEE		FA 93
08/24/93	ROOM RENT		FA 93
08/24/93	CASH RECEIPT		FA 93
	CURRENT BALANCE	**$1,833.71**	

NOTE: THIS STATEMENT REPRESENTS YOUR BALANCE PER THE ABOVE DATES. ANY QUESTIONS SHOULD BE FORWARDED TO THE OFFICE OF STUDENT ACCOUNTS.

FISCAL YEAR 91 - 92 HOWARD UNIVERSITY

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OFFICE OF THE BURSAR
STATEMENT OF ACCOUNT FOR PERIOD ENDING 06/30/92

ID NUMBER: 086463
STUDENT NAME: SHEPHARD, ANGELA
SCHOOL: SN
CLASS: 1

BALANCE AT BEGINNING DATE 06/30/91 - 0.00

DATE	TRANS/DESCRIPTION	AMOUNT	SEM/YR
08/18/91	CASH RECEIPT		FA 91
09/20/91	TUITION		FA 91
09/20/91	ENDOWMENT FEE		FA 91
09/20/91	SELF HELP FEE		FA 91
09/20/91	STUDENT ACTIVITY FEE		FA 91
09/20/91	MATRICULATION FEE		FA 91
09/20/91	HEALTH INSURANCE FEE		FA 91
09/20/91	LATE REGIST. FEE		FA 91
09/27/91	ROOM RENT		FA 91
10/03/91	MEAL PLAN		FA 91
10/03/91	DEFERRED PAYMENT FEE		FA 91
10/25/91	LATE REGIST. FEE		FA 91

FISCAL YEAR 91 - 92

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OFFICE OF THE BURSAR
STATEMENT OF ACCOUNT FOR PERIOD ENDING 06/30/93

ID NUMBER: 086463
STUDENT NAME: SHEPHARD, ANGELA
SCHOOL: SN
CLASS: 1

BALANCE AT BEGINNING DATE 06/30/91 - 0.00